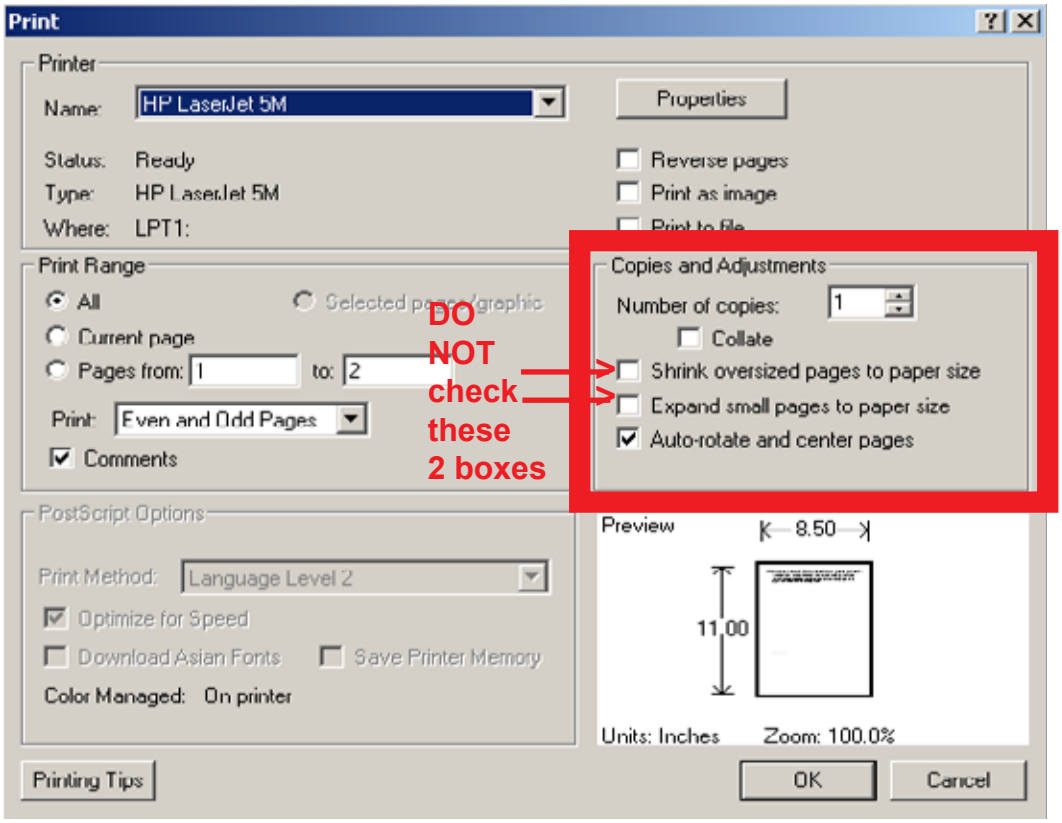
# Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



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Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

# A. Contents:

## Expired Physician Assistant Credential Activation Application Packet (Expired Less Than Three Years)

1. 656-131 ..... Contents List/SSN Information/Deposit Slip ..... 1 page
2. 656-118 ..... Application Instructions for Expired Physician Assistant Credential Expired Less Than 3 Years ..... 2 pages
3. 656-117 ..... Application For Expired Physician Assistant Credential Activation Expired Less than 3 Years ..... 2 pages

# B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

# C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

**Cut along this line and return the form below with your completed application and fees.**

## Physician Assistant
(Expired Less Than 3 Years)

## DEPOSIT SLIP

NAME (Please Print) _____ DATE _____

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

**Please note amount enclosed, and return with your application.**

$ _____

☐ **Check**
☐ **Money Order**

DOH 656-131 (REV 6/2006)

1F 0252110000 00430

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STATE OF WASHINGTON
DEPARTMENT OF HEALTH

# Application Instructions for Expired Physician Assistant Credential

# Expired Less Than Three Years

Attached is the application for activation of your expired Washington State credential. When your application is received by the Department of Health, it will be reviewed for completeness. If additional documentation is required, you will be sent an acknowledgment letter noting receipt, and any outstanding documentation needed to complete the process. This is the only notice you will receive while your application is pending. Applicants are discouraged from calling to check on the status of re-activation until you receive either your license or the acknowledgment letter. Your cooperation is requested to permit program staff to prepare your file and/or re-activate your license at the earliest possible time.

To ensure that you have submitted the necessary fees and documentation, we encourage you to use the following checklist:

☐ Pay $150.00 in total fees. **(All fees are non-refundable)**

## Application for Expired Physician Assistant Credential Activation

☐ ***Section 1: Demographic Information*.**

**Name**: Please list your current name with middle initial.

**Residential Address**: Please identify the address to which you wish all correspondence, including your credential, delivered. This will become your address of record for all Department of Health transactions until we are notified of a change.

**Telephone Number**: Enter current number where you may be reached during normal business hours.

**Social Security Number**: Required for license under 42 USC 666 and Chapter 26.23 RCW.

**Additional Data**: This information is required to update the Department's Database, and confirm information from your previous (initial) application.

☐ ***Section 2: Previous Credentialing*.** List ***all*** credentials you have held since last being credentialed in Washington State. List in chronological order, most current first. Include your last active credential in Washington State. If you need additional space, attach on a separate piece of paper.

☐ ***Section 3: Professional Experience.*** In chronological order, list all professional work experience since your Washington State credential has expired. Please identify all time breaks of 30 days or more. If you need additional space, attach on a separate piece of paper.

☐ ***Section 4: AIDS Education and Training Attestation.*** Required by WAC 246-12-040 and 246-919-380.

☐ ***Section 5: Criminal and Disciplinary Action Attestation.*** Required by WAC 246-12-040. This section pertains to formal or informal disciplinary action by any regulatory authorities, hospitals, state or federal jurisdictions, criminal convictions, and civil judgments connected with the practice of medicine. If you are unable to attest that you have not had action, please provide a synopsis of the situation, as well as the appropriate supporting documentation. **The Department does criminal background checks on all applicants.**

☐ ***Section 6: Continuing Education Attestation.*** Required by WAC 246-12-040 and 246-919-430.

☐ ***Section 7: Applicant's Attestation.*** Required to be signed and dated in order to process the application. Please read thoroughly to ensure your understanding of the provisions in this section.

Upon completion of reissuance requirements, your license will be reactivated from the completion date to your ***second*** birthday following that date. The license will be renewable every two years thereafter.

Applications and fees are to be sent to:

DEPARTMENT OF HEALTH
Medical Quality Assurance Commission
P.O. Box 1099
Olympia, WA 98507-1099

All other inquiries and documents should be directed to:

DEPARTMENT OF HEALTH
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98504-7866
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

| FOR OFFICE USE ONLY |
|---|
| VALIDATION: |
| ISSUANCE DATE: |
| RECEIVDED DATE: |

Credential #

# Application For Expired Physician Assistant Credential Activation (Expired Less Than 3 Years)

**Please Type or Print Clearly—**Follow carefully all instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

All applications must be accompanied by the applicable fee. Make remittance payable to the Department of Health.

## 1. Demographic Information

| APPLICANT'S NAME LAST | FIRST | MIDDLE NAME OR INITIAL |
|---|---|---|
| | | |

RESIDENTIAL ADDRESS

| CITY | STATE | ZIP | COUNTY |
|---|---|---|---|
| | | | |

NOTE: Your credentialing document will show this address and all correspondence from the Department will be sent to this address until you notify us in writing of a change. Pursuant to WAC 246-12-310, it is your responsibility to maintain a current mailing address on file with the Department.

| TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS.) | SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW) |
|---|---|
| ( ) | — — |

| GENDER | BIRTHDATE (MONTH/DAY/YEAR) | PLACE OF BIRTH (CITY/STATE) |
|---|---|---|
| ☐ Female ☐ Male | / / | |

Have you ever been known under any other name(s)? ☐ Yes ☐ No

If yes, list other name(s):

## 2. Previous Credentialing (Since Last Being Credentialed in Washington State)

| STATE/JURISDICTION | PROFESSION | CREDENTIAL | | | METHOD OF CREDENTIALING | CURRENTLY IN FORCE |
|---|---|---|---|---|---|---|
| | | TYPE | YEAR ISSUED | NUMBER | | |
| | | | | | | ☐ NO ☐ YES |
| | | | | | | ☐ NO ☐ YES |
| | | | | | | ☐ NO ☐ YES |
| | | | | | | ☐ NO ☐ YES |

## 3. Professional Experience (Since Expiration of Your Washington State Credential _____)

| NATURE OF EXPERIENCE OR PRACTICE AND LOCATION | DATES OF EXPERIENCE | |
|---|---|---|
| | FROM (MO/YR) | TO (MO/YR) |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## 4. AIDS Education and Training Attestation

I certify I have completed the minimum of four (4) hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS

## 5. Criminal and Disciplinary Action Attestation

I certify that no action has been taken by any state or federal jurisdiction or hospital, which would prevent or restrict my right to practice my profession.

I further certify that I have not voluntarily given up any credential or privilege or have not been restricted in the practice of my profession in lieu of or to avoid formal action.

APPLICANT'S INITIALS

**The Department does criminal background checks on all applicants.**

## 6. Continuing Education/Continuing Competency Attestation (If Applicable)

I certify that I have met all continuing education and competency requirements for the past two years. I am enclosing documentation on all courses attended/claimed.

APPLICANT'S INITIALS

## 7. Applicant's Attestation

I, _____ , certify that I am the person described and identified in
NAME OF APPLICANT

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

SIGNATURE OF APPLICANT

DATE

**Official Use Only**

**Washington State Records Center**